"Programmatic Perspective"
Presentation
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Medicare/Medicaid Integration Program

Introduction

Mr. Chairman and members of the Special Committee on Aging, my name is Mark Meiners. I am an associate professor at the University of Maryland where I specialize in the economics of aging and health as it relates to public policy. Over the last several years I have helped the Robert Wood Johnson Foundation develop and direct several programs designed to improve our Nation's long-term care financing and delivery systems. Today I want to focus on one such initiative, the Medicare/Medicaid Integration Program.

In 1996 the Robert Wood Johnson Foundation (RWJF) and the University of Maryland Center on Aging launched the Medic are/Medic aid Integration Program (MMIP). The purpose of the Program is to help end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. Persons eligible for both Medicare and Medicaid are often in need of extensive acute and long-term care, which also, not surprisingly, makes them the most expensive cases for both programs. The MMIP is designed to help states design and implement managed care programs that overcome the clinical, financial and administrative inefficiencies that exist in the traditional interface of these programs.

The Foundation has made $8 million available for this initiative. Selected states can receive grants to for research, program development and implementation activities. States currently included in the Program are Colorado, Florida, Minnesota, the New England Group (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont), and Texas. Technical assistance activities focus on issues of special interest such as:

- Integration of Acute and Long-Term Care for Dually Eligible Beneficiaries through Managed Care
- Collection and Use of Data: State Operated Managed Care Programs for Dual Eligibles
- Consumer Involvement in Managed Care Programs Serving Persons Dually Eligible for Medicaid and Medicare

In the remainder of my comments I want to share with you some of the background motivation for this program and alert you to some of the challenges that states face in seeking better systems of care for the dual eligibles.

Why States?

It is not surprising that states have been the focal point in reform of long-term care. Much of long-term care is related to daily living needs rather than health care needs. This tends to make the approach to care more the concern of individuals and their communities. Perhaps even more important, financing and administration of long-term care under the Medicaid program has been an increasing burden for states. Their desire to find cost-effective alternatives to nursing home care has provided much of the

experience with program innovation. States are hungry for workable models to help deal with their long-term care responsibilities.

Why the dual eligibles?

There is growing recognition of the need to improve the health care delivery system for those with chronic care needs. A commonly accepted premise is that to make progress we must improve the integration and coordination of acute and long-term care. The nearly 6 million people eligible for Medicare and Medicaid provide a unique and compelling, population to drive the development of integrated systems of care that deal with chronic illness. Many in this group have complex medical and chronic care needs that require lengthy stays in a variety of long-term settings. Effective care management for such a population can best be accomplished when health plans have the ability to coordinate the service delivery and financing of the entire continuum of health and long-term care services.

The "duals" comprise a significant part of the population in each program of those eligible for Medicare are also eligible for Medicaid while 17% of those eligible for Medicare are also eligible for Medicaid. Even more important is the fact that they have disproportionately high acute and long-term care costs - the "duals" account for 30% of Medicare costs and 35% of Medicaid costs. So for this unique population the government is already responsible for paying for an extensive array of primary, acute, subacute, and long-term care services. As such the government is well positioned to benefit significantly if those services can be delivered more efficiently. Perhaps even more compelling is the fact that an investment in the systems of care for the duals could serve as a model to the private sector - we need more investment in appealing systems of care that encourage private insurance for long-term care.

Why managed care?

The recent growth of Medicare and Medicaid beneficiaries enrolled in managed care has been unprecedented. Since 1993, Medicare enrollment has increased by over 60 percent and Medicaid enrollment by over 140 percent. Almost 4 million Medicare beneficiaries are now enrolled in managed care, representing more than 10 percent of the total Medicare population. While Medicaid's early involvement with managed care has focused on families and children, state policymakers are increasingly interested in enrolling all Medicaid beneficiaries into some form of managed care. The expansion of managed care for aged and disabled populations inevitably raises the question of how Medicare's acute care services can be coordinated with Medicaid's long-term care services. The integration of acute and long-term care is important to the development of a coordinated managed health care system that provides the flexibility and incentives to manage the full array of care for aged and disabled consumers.

Is there experience to build on?

The problem of fragmentation between Medicare and Medicaid is not new. Since the mid 1980s, policymakers have been looking for ways to end the fragmentation that seems inherent in a fee-for-service system that funds different types of care through multiple funding sources for a single group of clients. Beginning with The Channeling Project and On Lok in 1980s, and continuing with the Program For All-inclusive Care For The Elderly and the Social Health Maintenance Organizations, a variety of efforts have been made to create the necessary incentives for managed care providers to integrate acute and long-term care. These efforts form a vision of integrated care that includes the full continuum of acute and long-term care services, and allows providers to purchase the most efficient service package for their clients, regardless specific payer regulations.

In 1992, The Robert Wood Johnson Foundation made a grant to the State of Minnesota to plan a managed care program that integrates acute care services under Medicare with long-term care services under Medicaid. In 1995, the Minnesota Senior Health Options program received federal approval to proceed with a demonstration program to enroll and capitate health maintenance organizations and other health plans for the entire continuum of care for dual eligible persons over age 65. The program began enrolling members in March of 1997.

Challenges

The current financing and delivery systems for Medicare and Medicaid contain many obstacles to the development of an integrated system. Of major concern to the development of managed care programs is the fragmentation of financing and responsibility for patient care. Medicare and Medicaid currently maintain wholly separate contracting, reimbursement and quality standards for managed care organizations, in spite of overlapping populations. For example, the unnecessary hospitalization of those in nursing homes is encouraged by low Medicaid reimbursements, bed hold day payments, and DRG related payment incentives for short stay hospital admissions. Medicare physician payments are biased toward hospital care instead of care in the office, home, or nursing home. The result: more emergency room visits, medical transportation, and readmissions.

If managed care providers are to be effective in accessing the most appropriate and cost effective care for their patients they must be encouraged to use the entire continuum of care. Current Medicare and Medicaid policy have made this an extremely difficult task. To accomplish the integration and coordination of acute and long-term care we must develop new systems of care and financing. Managed care is increasing being looked to as one way to correct the inefficiencies of the current fragmented system. The hope is to integrate the financing and administrative rules to give providers the incentives and the flexibility to delivery the most appropriate care needed.

The experience of developing and implementing the Minnesota Senior Health Options program, has increased our understanding of the problems that must be solved to accomplish integrated care programs. Pam Parker, the director of the MSHO program has recently synthesized her experiences into the following set of conclusions and recommendations for further progress in the development of integrated care systems for the dual eligible (a full paper is available):

1. HCFA should reduce barriers to enrollment of dual eligible in Medicaid managed care.

Current HCFA policy should be changed to allow states to restrict payment of the Medicare coinsurance to Medicaid plan networks as those networks have adequate choices of physicians and other providers, similar to the arrangements in Minnesota's PMAP program, Arizona and Oregon. Without this change states cannot manage costs including those for long term care for dual eligibles and consumers will face an even more fragmented and uncoordinated system of care.

2. OMB must change budget neutrality cap methodologies for voluntary enrollment models.

A fairer budget neutrality formula must be addressed before states can move forward with better service models for the dually eligible. The current methodology was designed for mandatory enrollment models where all eligibles are expected to be in the demonstration. It does not account for adverse selection in the mix of persons voluntarily enrolling in these projects. Projects like that in Minnesota which are attracting a large number of nursing home residents would be unfairly disadvantaged because the cap method does not account for "case-mix". Because of this problem OMB is applying an alternative

method to several state demonstrations (MN, CO, NY and WI) which caps Medicaid costs for the entire eligible population in the county or counties in which the demonstration is held even though only a few of those eligibles actually enroll in the demonstration. This method puts the state at risk for federal financial participation (FFP) for Medicaid costs which would be fully covered if left under fee-for-service, in effect penalizing a state which wants to demonstrate new methods of serving this population. This is too high a price for states to pay for innovation and remains a huge deterrent to moving forward in demonstrating better methods of financing and service delivery for this population.

3. HCFA should allow more 1115/222 demonstrations.

While there may be some circumstances unique to Minnesota that led to certain waiver provisions that HCFA does not want to replicate, it is important that other states have the opportunity to pursue similar approaches. HCFA should continue to work with states who demonstrate the capacity to manage such coordinated programs for dual eligibles. In fact, very soon these approaches must move away from research and demonstration project status and become permanent features of the Medicaid and Medicare programs. States like Arizona prove that long term care can be effectively administered under a managed care system and models like PACE and SHMO and Minnesota's MSHO demonstration show that it is possible to merge Medicare and Medicaid financing.

Though it may seem premature to incorporate integrated financing models for dual eligibles into Medicare and Medicaid now, in a few years demographics are going to force this issue for us. We already know that the current fee for service system is fraught with problems. Use of managed care techniques can actually increase accountability in a system where accountability is fragmented and difficult to pinpoint. We should begin now to incorporate the tools we know will be needed for the future into the Medicare and Medicaid programs so that these approaches mature before the demographic crisis overwhelms our resources.

4. Devote far more resources to quality assurance (QA) measures for chronic care populations enrolled in managed care.

Minnesota's managed care licensing and consumer protection standards match or exceed all federal standards for Medicare risk contractors. However, many states lack strong oversight mechanisms. In general, current QA requirements and oversight procedures for both Medicare and Medicaid may be inadequate to protect dual eligibles when profit incentives have the potential to overshadow the benefits managed care can bring to this population. As states step up efforts to enroll dual eligibles in various managed care arrangements, far more resources must be invested in adapting oversight and monitoring systems for Medicare and Medicaid managed care to address the needs of a more vulnerable population.

While the application of HEDIS measures to Medicare and Medicaid plans and requirements for Medicaid encounter data are steps forward, they barely begin to address the complex issues in outcome measurement for frail elderly and disabled. HEDIS measures do not really address a population which largely resides in a nursing home. For example the Health of Seniors measure uses the SF 36 assessment instrument to assess changes in function over time but it most of the questions included are not relevant to frail nursing home residents. The planned methodology for administration of the CAHPS satisfaction survey (telephone interviews) is not appropriate for obtaining accurate information from nursing home residents who are largely cognitively impaired. (We understand that HCFA may be working to resolve this issue.)

HCFA is placing much effort on methods of assuring provider quality in specific settings (e.g. the OASIS assessment instrument for persons served by certified home care agencies and the MDS

assessment in nursing homes) but these approaches may perpetuate fragmented "silobased" care where each provider is regulated as if they were operating individually rather than as one of many who may be involved in the care of a frail individual throughout that individual's course of care or treatment. These site based approaches give us only snapshots of an individual's care in a given setting rather than an understanding of how care has been provided and managed overall. Providers will continue to operate in a fragmented system where no locus of accountability for integrated care can be identified unless more emphasis is placed on the links between providers. It is not clear how these efforts will relate to new measurement approaches for managed care such as HEDIS but integration of these parallel efforts should be explored.

If we are truly concerned about fragmentation of care and duplicative or uncoordinated provider efforts, it may be more important to begin to assess how care for dual eligibles is coordinated between settings of care, and to develop instruments to monitor what happens to care outcomes and patient satisfaction over time as they are served by different parts of the system. The National Chronic Care Consortium (with which the State of Minnesota has a contract to assist with integration of clinical care for MSHO plans), has developed a tool for assessing how well different parts of the system are working together. This kind of tool can be the basis for development of new methods to monitor care outcomes of individuals over time and across settings.

5. Provide increased resources for ombudsman and consumer education.

Even if states are not allowed to step up efforts to enroll dual eligibles in Medicaid managed care plans, enrollment of dual eligibles is likely to increase rapidly under Medicare+ Choice. Many traditional consumer advocate groups such as those working with nursing home residents are unprepared to deal effectively with managed care plans and lack the resources to cope with the new rules of the game they are encountering. Many more resources need to be invested in strong consumer advocacy and consumer education programs targeted directly to the most frail dual eligible groups such as nursing home residents.

It appears inevitable that capitated payment approaches are to be important tools for managing care and services for dual eligibles in the future just as they are for other parts of the Medicare population. While it is possible to maintain and even improve quality and accountability of care and services in capitated financing arrangements, responsible policy makers and state Medicaid managers can never ignore the down side of capitation. Lack of strong consumer protections, poorly informed advocates and enrollees and inattentive oversight can doom state managed care programs for dual eligibles to failure. Funding to strengthen these functions is necessary to assure the credibility of the system in the long run.

6. Pursue system-wide solutions to administrative conflicts.

Many states really have no choice but to seek better ways to coordinate Medicaid services with Medicare+Choice because this enrollment is growing and the problems with coordinating benefits for dual eligibles are immediate. HCFA too appears more open to creative solutions to the administrative and enrollment conflicts for dual eligibles and has even created new initiatives around dual eligible issues, but much more needs to be done and HCFA's resources in this area seem to be minimal. HCFA's Medicare policies for administration of Medicare +Choice plans still do not take into account the special issues around dual eligibles. Many of these problems could be solved by systematic solutions involving coordination of Medicare and Medicaid policy at the HCFA level and by building some policies to address issues for dual eligibles into Medicare's administration of managed care plans. This would be far more efficient than the plan by plan, state by state, region by region solutions being pursued now.

Summary Discussion

These conclusions and recommendations are meaty and not without controversy. According to HCFA, Medicare choice cannot be legally waived and there is considerable caution about all other waivers. Indeed, states working to develop integrated care programs for dual eligibles feel they have been faced with a seemingly endless set of barriers associated with the waiver approval process. Colorado (using the 1115 research and demonstration waiver authority) has been in limbo for nearly three years trying to start a relatively straightforward pilot project which seeks to integrated Medicaid financing within a Medicare HMO. More encouraging is Texas which has recently began their program using a different waiver authority (1915 b,c program waiver authority) that may well represent the "waive(s)" of the future since it seems to have a quicker turnaround process. But the ability to integrate with Medicare effectively still remains a question. While it is often hard to pin down all the reasons for the delays, it can often be traced to explanations that hinge on no clear HCFA precedence on how to proceed. This can have the effect of double jeopardy since there is also fear of setting a precedence.

The recently passed Balanced Budget Act contains a number of provision which should eventually help states accomplish integrated care demonstrations but key barriers remain. States still cannot avoid the waiver process for most of what they would like to try and, while there will be a new risk adjustment methodology, it will not take into account measures of functional dependency known to be important indicators of health care costs. This could be a barrier to provider participation. HCFA and the states are beginning to explore the feasibility of using the 222 reimbursement and payment waiver authority under Medicare to see if it will allow states that use the 1915 waiver approach some way to adjust for this problem.

The desire for a broad based budget neutrality criteria on the part of the Office of Management and Budget that puts states at risk of losing some of their Federal contribution to Medicaid could be a real stumbling block for states since they are generally not in a good position to take on more Medicaid cost. Combined with the desire to keep the Medicare and Medicaid budget neutrality calculations separate, this suggests a basic distrust of these new program ideas. That makes for a very tough demonstration environment and often puts the providers in the unenviable position of bearing significant risk if the programs are to go forward. Considering that there are also cutbacks proposed in key areas of Medicare such as the home health care benefits the state's interest pursuing integrated care projects could quickly dissipate.

That would indeed be unfortunate. The integration of Medicare and Medicaid programs for the dual eligibles represents an important opportunity for us to develop the kinds of acute and long-term care systems that will be needed for our rapidly growing senior population. The knowledge of how to do this is not sitting on the shelf someplace. It must be developed and that will take an investment. States have begun this process, but need more of a "can do" waiver review process to help them get their programs implemented. can we learn the real lessons of how to provide good integrated.